

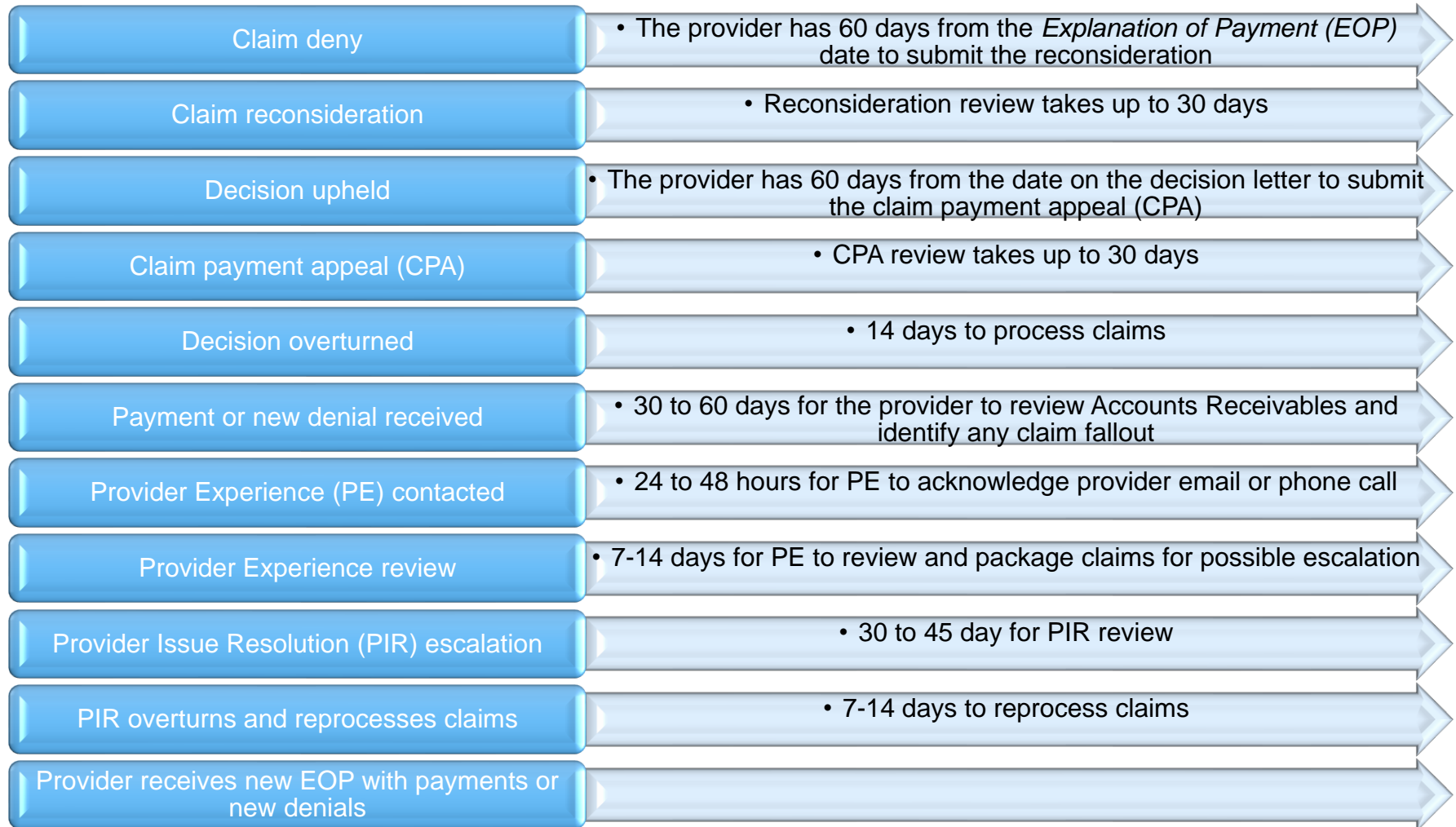


Claims 201: A provider success story

2021 Indiana Health Coverage Programs (IHCP) Works Virtual Seminar



The timeline of events



Claims resolution process

Claims reconsideration — 1st step

- Must be received within 60 calendar days from the date on the remittance advice (RA). Disputes can be done verbally through Provider Services, in writing, or online through the Availity Portal.* Submit a claims reconsideration if you disagree with full or partial claim rejection or denial, or the payment amount.

Claim payment appeal (CPA) — 2nd step

- If you are not satisfied with the reconsideration, you may submit a claim payment appeal. We must receive this appeal within 60 calendar days from the date of the claims reconsideration. This can also be done via the Availity Portal.

Scenario

A provider group had laboratory claims denying for invalid *Clinical Laboratory Improvement Amendments (CLIA)* numbers.

The following presentation will highlight the steps taken to reach resolution including the partnership between the provider and their Provider Experience manager.

All information has been blurred to protect the identity of our members and providers.




The claim submission

Availity claim submission

- Select **Responsibility Sequence**:
 - Primary
 - Secondary
 - Tertiary
- Fill in the *patient information* section:
 - All fields with the red asterisk (*) are required fields.

Home > Select > Professional Claim

Professional Claim

[Give Feedback](#) 

Fields marked with an asterisk * are required.

INSURANCE COMPANY/BENEFIT PLAN INFORMATION

* Responsibility Sequence ⓘ
Primary

PATIENT INFORMATION

Select a patient. (Patients in the list are from your eligibility and benefits inquiries in the last 24 hours for the current organization)
Type to search...

* Last Name * First Name Middle Name or Initial Suffix
Country ⓘ Address ⓘ Suite ⓘ
United States City State Zip Code
Type to search...
Date of Birth Date of Death * Gender * Relationship ⓘ
mm/dd/yyyy mm/dd/yyyy Type to search... Self

Patient Amount Paid ⓘ

☐ Release signature from provider on behalf of patient

ANCILLARY CLAIM/TREATMENT INFORMATION

Patient's Condition is Related To: (Select all options that apply to patient's condition)

- ☐ Current or previous employment
- ☐ Auto accident
- ☐ Other accident

Availity claim submission (cont.)

The subscriber ID goes here as well as their other insurance if there is another policy.

When entering the subscriber ID, be sure to enter the prefix YRH or YRK, plus the state Recipient Identification Number (RID).¹

¹ Note: effective April 1, 2021, this is required for all Hoosier Care Connect members. Hoosier Healthwise and Healthy Indiana Plan (HIP) members can be entered with the RID or Anthem Blue Cross and Blue Shield (Anthem) ID.

SUBSCRIBER INFORMATION ⓘ

* Subscriber ID ⓘ

Policy or Group Number ⓘ

* Authorized Plan to Remit Payment to Provider? ⓘ
Type to search... | v

☒ SECONDARY INSURANCE PLAN INFORMATION ⓘ

* Subscriber ID ⓘ

Policy or Group Number ⓘ

Remaining Patient Liability

☐ This subscriber is different from the primary subscriber

☐ This is a Medicare payer

* Other Payer Name

* Other Payer ID ⓘ

Other Payer Identification Number

Other Payer Claim Control Number

* Information Release ⓘ
Type to search... | v

* Claim Filing Indicator

* Other Payer Benefits Assignment Certification ⓘ

Country ⓘ

Address ⓘ

Suite ⓘ

City

State
Type to search... | v

Zip Code

☐ Release signature from provider on behalf of patient

Employer's Identification Number ⓘ

Prior Authorization Number ⓘ

* Payment / Adjustment Type ⓘ

☐ Claim Adjustment Indicator

☐ OUTPATIENT MEDICARE ADJUDICATION INFORMATION

Availity claim submission (cont.)

The provider's billing information goes into this field.

BILLING PROVIDER

Select a Provider ?
Type to search... | v

* NPI ?
Type to search... | v

Specialty Code
Type to search... | v

Payer Assigned Provider ID (PAPI)
Type to search... | v

* Organization or Last Name ?
Type to search... | v

First Name
Type to search... | v

Middle Name
Type to search... | v

Contact Name ?
Type to search... | v

* EIN ?
Type to search... | v

* SSN ?
Type to search... | v

Country ?
United ... x | v

* Address ?
Type to search... | v

Suite ?
Type to search... | v

* City
Type to search... | v

* State
Type to search... | v


* Zip Code
Type to search... | v

☐ PAY TO ADDRESS (IF DIFFERENT FROM BILLING PROVIDER ADDRESS)

Availity claim submission (cont.)

Enter claim service line information here:

- Select your *Place of Service*.
- Providers will need to enter:
 - Service start date
 - Procedure code
 - Charge amount
 - Quantity
 - Quantity type
 - Prior Authorization number (if required)
 - Any modifiers
 - Diagnosis pointer (up to 4)
 - CLIA information (if required)



1

Service Line Control Number ? 1	Place of Service Type to search... v		
* Service Start Date ? mm/dd/yyyy	Service End Date mm/dd/yyyy		
* Procedure Code ? Type to search... v	Procedure Description 		
* Charge Amount 	* Qty ? 	* Quantity Type ? Unit v	<input type="checkbox"/> This claim was an emergency
Prior Authorization Number 			
Modifier 1 	Modifier 2 	Modifier 3 	Modifier 4
* Diagnosis Code Pointer 1 ? Type to search... v	Diagnosis Code Pointer 2 Type to search... v		
Diagnosis Code Pointer 3 Type to search... v	Diagnosis Code Pointer 4 Type to search... v		
Clinical Laboratory Improvement Amendment Number 	Referring Clinical Laboratory Improvement Amendment Number 		
Additional Information Line Note 			

The claim

This is how the submission looks in a *CMS-1500* claim form.

The image shows a portion of a CMS-1500 claim form. A blue arrow labeled "CLIA NUMBER" points to the "23. PRIOR AUTHORIZATION NUMBER" field, which contains "CLIA: [REDACTED]". Below this is a table with columns for "24. A. DATE(S) OF SERVICE", "B. Place Of Service", "C. ENG", "D. PROCEDURES, SERVICES, OR SUPPLIES", "E. DIAGNOSIS POINTER", "F. CHARGES", "G. DAYS OR UNITS", and "H. EPSO Famil Plan". The table has 6 rows. A blue box highlights the first four rows of the table. The first row contains "99213" in column D, "3:1:2:4" in column E, and "U1" in column H. The second row contains "81025" in column D, "QW" in column E, and "U1" in column H. The third row contains "87210" in column D, "1" in column E, and "U1" in column H. The fourth row contains "87210" in column D, "QW" in column E, and "U1" in column H. The fifth row is empty. The sixth row is empty. A mouse cursor is visible on the left side of the table.

24. A. DATE(S) OF SERVICE		B. Place Of Service	C. ENG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS Modifier	E. DIAGNOSIS POINTER	F. CHARGES	G. DAYS OR UNITS	H. EPSO Famil Plan
1				99213	3:1:2:4		U1	
2				81025	QW	1	U1	
3				87210	1		U1	
4				87210	QW	1	U1	
5								
6								

Explanation of Payment (EOP)

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: PATIENT ACCOUNT#: SERVICE PROVIDER NAME: NETWORK: IN NETWORK RELATIONSHIP TO INSURED:													
	99213			60.38	0.00	0.00	0.00	0.00	55.62	PXN 45	0.00		60.38
	81025QW			8.61	0.00	0.00	0.00	0.00	17.13	PXN 45	0.00		8.61



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CHECK/EFT:

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: PATIENT ACCOUNT#: SERVICE PROVIDER NAME: NETWORK: IN NETWORK RELATIONSHIP TO INSURED:													
	87210			0.00	0.00	0.00	0.00	0.00	23.00	GLI 16	0.00		0.00
	87210QW			0.00	0.00	0.00	0.00	0.00	23.00	GLI 16	0.00		0.00
	TOTAL:			68.99	0.00	0.00	0.00	0.00	118.75		0.00		68.99
INTEREST													0.00
TOTAL NET PAID													68.99

EOP (cont.)

Explanation codes

00	GLI 16
00	GLI 16
15	

EXPL CODES	EXPLANATION
TFO	This claim was submitted after the claim filing limit.
PXN	Paid per your contract or Out Of Network rates
GLI	A valid CLIA number must be submitted for this service

Reconsideration

Providers can indicate in their reconsideration that it affects more claims for other members.

IsImpactingMoreClaimsForOtherMembers

Yes

Reconsideration (cont.)

Supporting documentation

CLIA Laboratory Demographic Information Report

Report Options

CLIA Number: 1 [REDACTED]

Certificate / Application Type	Name and Address / CLIA Number	Telephone #	Certificate Expiration Date	Lab Testing Performed In
Accreditation	[REDACTED] #1 [REDACTED]	[REDACTED]	2/11/2021	[REDACTED]

Decision

June 12, 2020

Member ID : [REDACTED]
Member Name: [REDACTED]
DOB: [REDACTED]
Patient account number: [REDACTED]
Request Number: REQ-GBD-[REDACTED]
Dispute Level: Reconsideration

Subject: Claims Payment Reconsideration decision

Dear [REDACTED]

Thank you for taking the time to contact Anthem Blue Cross and Blue Shield regarding the above-referenced claim payment dispute. We received your claim payment dispute on 05/28/2020. After thorough review of the information provided, a decision has been reached on the claim(s) associated with your dispute.

We have upheld the claim(s) associated with the above request.

Details for each claim associated with your dispute are outlined below:

Claim #	Decision	Decision Date	Decision Code
[REDACTED]	Upheld	6/12/2020	RD10, DRAI

Decision code explanations

RD10: Additional payment is not appropriate for the services rendered.

DRAI: Effective 5/26/2020 IN is not apart of the exception rule. All laboratory claims has to be billed with valid CLIA code no matter the place of service. Per the Laboratory Demographics Lookup CLIA code on the claim image is not a match. Denial upheld.

Our decision is that your claim(s) could not be adjusted; therefore, you have the right to a second-level payment appeal. We must receive your request in writing within 30 calendar days of the date of this letter. Second-level appeals are not accepted verbally.

As a reminder, you may not bill the member for these services as a result of our denial of payment because:

- Medicaid members must receive prior notification in writing, including a list of the specific service(s) to be rendered and the reason(s) why the service(s) will not be covered, and the amount of financial liability associated with the services to be held liable for payment.
- It is a violation of the Anthem *Participating Provider Agreement* to balance bill members for covered services, even if the member was notified and agreed to pay before services were rendered.

We appreciate your patience. If you have questions about this letter or your claim payment review request, call the Customer Care Center at "Hoosier Healthwise: 1-866-408-6132 Healthy Indiana Plan: 1-844-533-1995 Hoosier Care Connect: 1-844-284-1798 ". Thank you for being part of our provider network.

Sincerely,

Claim Payment Disputes
Anthem Blue Cross and Blue Shield

THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE MEDICAL PROVIDER TO WHOM IT IS ADDRESSED AND MAY CONTAIN HEALTH INFORMATION THAT IS PROTECTED BY LAW.

If this transmission contains the protected health information of an individual who is unknown to your practice,

Claim payment appeal (CPA)

Case Actions Associated Cases

External Request Information

External App Name
Availity

Phone Number

Requested By
Provider

Sub Category

Company Received Date
6/17/20 12:09 PM

Communication preference
Web

Create Operator Name
default, default

IsImpactingMoreClaimsForSameMember
Yes

External Request ID

Comments

The appeal has been upheld, I am attaching a EOB with the same CPT code that has been paid with the same Clia Number. I have also attached a document from CMS that shows you Clia number. Please review all documents and complete a SWEEP from dates 1/01/2020 until present. I have over 100 claims where Anthem has denied our Lab CPT codes for the Clia Number. It is not just this one code is all different Lab CPT codes. Thank You

Priority
Standard

Is Provider Grievance

Escalation Flag

Intake Analyst Role
Call Center Agent

Decision
Overturned

IsImpactingMoreClaimsForOtherMembers
Yes

CPA (cont.)

Supporting documentation

CLIA Laboratory Demographic Information Report

Report Options

CLIA Number: 1 [REDACTED]

Certificate / Application Type	Name and Address / CLIA Number	Telephone #	Certificate Expiration Date	Lab Testing Performed In
Accreditation	[REDACTED] #1 [REDACTED]	[REDACTED]	2/11/2021	[REDACTED]

CPA (cont.)

The decision

July 15, 2020



Member ID : [REDACTED]
Member Name: [REDACTED]
DOB: [REDACTED]
Patient account number: [REDACTED]
Request Number: REQ-GBD-[REDACTED]
Dispute Level: Claim Payment Appeal

Subject: Claims Payment Appeal decision

Dear [REDACTED]

Thank you for taking the time to contact Anthem Blue Cross and Blue Shield regarding the above-referenced payment dispute. We received your claim payment dispute on 06/17/2020. After thorough review of the information provided, a decision has been reached on the claim(s) associated with your dispute.

This letter serves as our final determination. You have exhausted your internal dispute rights with Anthem. We have overturned the decisions on claim(s) associated with the above request.

Details for each claim associated with your dispute are outlined below:

Claim #	Decision	Decision Date	Decision Code
[REDACTED]	Overtured	7/15/2020	RD22

Decision code explanations

RD22: The original decision to completely or partially deny the payment in question has been overturned. You will receive a new Explanation of Payment and any appropriate payment within two weeks. Further, we have determined that the identified issue may have potentially impacted other processed claims. Therefore, we will be conducting a thorough review of all similar claims and adjusting them as appropriate. There is no need to submit another Appeal. You can expect any additional adjustments completed within 60 business



What's next?

What's next?

The provider had a decision to make

- In this case, the sweep missed claims, and they decided to pursue the missed claims because it was a large issue.
- But how do they go about that?

Claim #	Decision	Decision Date	Decision Code
	Overturned	7/15/2020	RD22

Decision code explanations

RD22: The original decision to completely or partially deny the payment in question has been overturned. You will receive a new Explanation of Payment and any appropriate payment within two weeks. Further, we have determined that the identified issue may have potentially impacted other processed claims. Therefore, we will be conducting a thorough review of all similar claims and adjusting them as appropriate. There is no need to submit another Appeal. You can expect any additional adjustments completed within 60 business

July 15, 2020

Member ID :
Member Name :
DOB :
Patient account number :
Request Number: REQ-GBD-
Dispute Level: Claim Payment Appeal

Subject: Claims Payment Appeal decision

Dear

Thank you for taking the time to contact Anthem Blue Cross and Blue Shield regarding the above-referenced payment dispute. We received your claim payment dispute on 06/17/2020. After thorough review of the information provided, a decision has been reached on the claim(s) associated with your dispute.

This letter serves as our final determination. You have exhausted your internal dispute rights with Anthem. We have overturned the decisions on claim(s) associated with the above request.

Details for each claim associated with your dispute are outlined below:

Claim #	Decision	Decision Date	Decision Code
	Overturned	7/15/2020	RD22

Decision code explanations

RD22: The original decision to completely or partially deny the payment in question has been overturned. You will receive a new Explanation of Payment and any appropriate payment within two weeks. Further, we have determined that the identified issue may have potentially impacted other processed claims. Therefore, we will be conducting a thorough review of all similar claims and adjusting them as appropriate. There is no need to submit another Appeal. You can expect any additional adjustments completed within 60 business

What's next? (cont.)

Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect



Physical Health Provider Experience Managers

Zone 1/Beacon Health Systems

Jessi Earls, Provider Experience Manager
Jessie.Earls@anthem.com • 1-317-452-2568

Zone 2/Ascension St. Vincent

Angelique Jones, Provider Experience Manager
Angelique.Jones@anthem.com • 1-317-619-9241

Zone 3

Jamaal Wade, Provider Experience Manager
Jamaal.WadeSr@anthem.com • 1-317-409-7209

Zone 4/Deaconess

Jonathan Hedrick, Provider Experience Manager
Jonathan.Hedrick@anthem.com • 1-317-601-9474

Zone 5/Parkview

David Tudor, Provider Experience Manager
David.Tudor@anthem.com • 1-317-447-7008

Zone 6/IU Health; St. Joseph Regional Medical Center; Home Health and Hospice

Matt Swingendorf, Provider Experience Manager, Sr.
Matthew.Swingendorf@anthem.com • 1-317-306-0077
Home Health and Hospice Providers
INMEDHHH@anthem.com

Zone 7/Baptist Health

Sophia Brown, Provider Experience Manager
Sophia.Brown@anthem.com • 1-317-775-9528

Zone 8/Eskenazi

Marvin Davis, Provider Experience Manager
Marvin.Davis@anthem.com • 1-317-501-7251

Zone 9/Out-of-State Providers, Franciscan, Community Health Network

Nicole Bouye, Provider Experience Manager, Sr.
Nicole.Bouye@anthem.com • 1-317-517-8862



Management:
Jacquie Marsalis, Director, Provider Experience
Jacqueline.Marsalis@anthem.com

Indiana Provider Network Solutions:
1-800-455-6805

- The provider contacted their Provider Experience manager.
- To find the map, go to <https://providers.anthem.com/in>
> Our Network > Network Relations Map

Provider Experience (PE)

- Who
 - Your assigned provider representative who is now called your Provider Experience manager
- Why
 - To provide an experience with Anthem Blue Cross and Blue Shield that is best-in-class
- What
 - Education
 - Claims issues
 - Answers to questions
 - Last resort in claim resolution after the dispute and appeal

PE (cont.)

- The provider submitted a few claim examples:
 - Usually 5 to 10 claim numbers
 - Reconsideration numbers
 - Claim payment appeal numbers
 - Since multiple claims can be disputed on one reconsideration and claim payment appeal, the provider sent that information.


PE (cont.)

What did the Provider Experience manager do?

- Advised the provider to allow time to research what has been done on this issue.
- During the research, the PE manager:
 - Reviewed the CPA to determine the outcome and see why claims were not fully reprocessed:
 - Were there notes to indicate why these have been missed?
 - Pulled claim examples to make sure that they were billed correctly.
 - Verified *CLIA* number is valid.

PE (cont.)

- CLIA verification



S&C QCOR

Home | Help | Resources | FAQs | Site Map

Search for a CLIA Laboratory

This website provides a listing of CLIA laboratories and other facilities that are certified by the United States Government Department of Health and Human Services under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 U.S.C. Â§263a to perform laboratory testing as of the Data Source Date listed below. The certificate type listed corresponds to the complexity of the testing that can be performed by the laboratory.

This website provides demographic information about laboratories, including CLIA number, facility name and address, where the laboratory testing is performed, the type of CLIA certificate, and the date the certificate expires. This list is updated monthly and represents the information in the system at the time of update. For additional information about a particular laboratory, contact the appropriate State Agency or Regional Office

To search for a Facility, please enter a Facility Name (full or partial name) or a CLIA Identification Number, select a State, or enter a zip code (full or partial zip code with * replacing missing number(s), such as 223**).

Notes: Search is only available for Active CLIA laboratories. Additionally, Department of Veterans Affairs (VA) laboratories are not found in the QCOR laboratory look up website. Contact Keith Morgan in the VA National Enforcement Office at keith.morgan4@va.gov; phone* (202) 632-8515.

Facility Name (or partial name):

Search for:

OR

CLIA Identification Number:

OR

State:

City:

OR

Zip Code:

OR

International: ☐ Check this box if you want international labs only

Note: Laboratories applying for a certificate of compliance or accreditation will receive a certificate of registration until compliance is determined.

Certification Type:

By Exemption Status:

Some states have applied for exemption from the federal regulations for the laboratories in their state. These states have enacted laws relating to laboratory requirements that are equal to or more stringent than CLIA requirements and the State licensure program has been approved by CMS. This exemption may apply to all laboratories in the state (full exemption), or only certain types of laboratories as determined by the state (partial exemption). Currently, Washington State has full exemption and New York State has a partial exemption.

☐ Check this box if you want exempt labs only

Go Back

Search

Download CSV

PE (cont.)

- CLIA verification

[Print](#) | [Close Window](#)

CLIA Laboratory Details

CLIA Identification Number:	
Facility Name:	
Address:	
Phone Number:	
Certificate Type:	Accreditation
Certificate Effective Date:	
Certificate Expiration Date:	02/11/2023
Facility Type:	

PE (cont.)

- **Claim escalation**

- Claim examples and the dispute numbers are packaged for review.
- Timely filing waiver is requested.
- If approved, claims are sent for review through our Escalation team.
- PE manager will notify the provider with the escalation number and advise to allow 30 to 45 days for the initial review to complete.

Success

- The claim denials were overturned and claims did reprocess:
 - Many of them resulted in payments.
 - Some hit another denial edit:
 - Provider was aware that it was a possibility and knew they would have the opportunity to dispute or correct if necessary.

Success

“We know that issues arise and claims deny. We know that by following your guidelines we feel good that we did our part to resolve the issue. But it’s great to know that if the process doesn’t work, or we just need some more information, we have someone at Anthem that we can ask and if necessary they will be an advocate in our corner to take another look.”

— Participating Provider

Enhanced PE

- Introduction of the Provider Issue Resolution (PIR) team:
 - Replaces the previous Provider Experience claim escalation process
 - PIR sees the claim project all the way through completion:
 - Does complex research
 - Identifies any system issues and will submit tickets to have those resolved
 - Communication with the providers throughout the process:
 - Notification that the escalation was received
 - Completion
 - Working toward reduced completion times
- All of this will allow PE managers to be our *feet on the street* and continue our valued partnership with our providers.

PE managers

Physical health Provider Experience managers

- **Zone 1/Beacon Health Systems**
Jessi Earls
Jessica.Wilkerson-Earls@anthem.com
317-452-2568
- **Zone 2/Ascension St. Vincent**
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- **Zone 5/Parkview**
David Tudor
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317-447-7008
- **Zone 6/IU Health; St. Joseph Regional Medical Health Center; Home Health and Hospice**
Matt Swingendorf
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317-306-0077
- **Zone 7/Baptist Health**
Sophia Brown
Sophia.Brown@anthem.com
317-775-9528
- **Zone 8/Eskenazi**
Marvin Davis
Marvin.Davis@anthem.com
317-501-7251
- **Zone 9/Out-of-state providers, Franciscan, Community Health Network**
Nicole Bouye
Nicole.Bouye@anthem.com
317-517-8862



Statewide behavioral health (BH) subject matter experts (SME)

Acute hospitals

Tish Jones, Provider Experience Manager
Latisha.Willoughby@anthem.com
317-617-9481

Community mental health centers/federally qualified health centers/rural health clinics

Matthew McGarry, Provider Experience Manager
Matthew.McGarry@anthem.com
463-202-3579

Substance use disorder (SUD)/Opioid treatment program (OTP)

Alisa Phillips, Provider Experience Manager, Sr.
Alisa.Phillips@anthem.com
317-618-2170

SME — SUD/OTP

Michele Weaver, Provider Experience Manager
Michele.Weaver@anthem.com
317-601-3031

Solo BH and applied behavior analysis providers

Zones 1, 2, 5, 6

Ashley Holmes
Ashley.Holmes@anthem.com
317-315-0623

Zones 3, 4, 7, 8

Whitney McTush
Whitney.McTush@anthem.com
317-519-1089

Questions





Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

<https://providers.anthem.com/in>

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Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

AINPEC-3477-21 September 2021